	London Borough of Hammersmith & Fulham **CABINET** **3 NOVEMBER 2014**
BETTER CARE FUND PLAN REVISED SUBMISSION	
Report of the Cabinet Member for Health and Adult Social Care - Councillor Vivienne Lukey	
Open Report	
Classification - For Decision **Key Decision:** Yes	
Wards Affected: All	
Accountable Executive Director: Liz Bruce, Executive Director for Adult Social Care and Health	
Report Author: Cath Attlee, Whole Systems Lead, Adult Social Care	**Contact Details:** Tel: 07903956961 E-mail: cattlee@westminster.gov.uk

1. EXECUTIVE SUMMARY

1.1. This paper reports on the requirement on each Health and Wellbeing Board to resubmit the Better Care Fund (BCF) Plan, which was previously agreed in March 2014 and submitted to the Department of Health (DH) in April. The report explains that the plan contains some additional material and revision following further guidance and a revised template from DH and the Department for Communities and Local Government (DCLG).

1.2. The key national changes relate to the Pay for Performance and Risk Sharing arrangements which mitigate the risk of local areas failing to achieve the key target of reduced emergency admissions, but reduce the investment in integrated care, and potentially increase the risk to social care.

1.3. Our revised submission includes more detailed financial modelling particularly around the development of a community independence service, which is a key element of the plan and provides partners with greater confidence of the deliverability of the five outcomes measured within the plan.

1.4. Local NHS investment reduces the risk to social care of non-delivery of the reduced emergency admissions target, since social care costs will be covered. However, there continues to be a risk to the whole system of the new arrangements generating additional demand, and this will need to be closely monitored.

2. RECOMMENDATIONS

2.1. To agree the Better Care Fund Plan Revised Submission and to proceed with the implementation of the plan, including the development of the Community Independence Service (CIS).

2.2. To note that Cabinet will be asked to make further key decisions during the implementation of the Better Care Fund programme and plans.

3. REASONS FOR DECISION

3.1. Development of an integrated Better Care Fund Plan is a requirement of the Department of Health and the Department for Communities and Local Government. Funding allocations to the Local Authority and to the local NHS in 2014-16 are dependent on agreement between the parties on the BCF Plan. In addition, the programme of work is consistent with the stated vision and objectives of the partners within the Hammersmith and Fulham Health and Wellbeing Board.

3.2. In July 2014 the DH/DCLG wrote to Health and Wellbeing Boards requiring a resubmission of the BCF Plan to strengthen the plans and provide greater confidence that the integration of out of hospital services would be delivered to reduce pressure on hospital care. Cabinet is asked to approve the resubmitted plan.

4. INTRODUCTION AND BACKGROUND

4.1. The BCF is “a single pooled budget for health and social care services to work more closely together in local areas, based on a plan agreed between the NHS and local authorities”. A national allocation of £3.8bn was announced in the summer of 2013 for this purpose.

4.2. The BCF does not come into full effect until 2015/16, but an additional £200m was transferred to local government from the NHS in 2014/15 (on top of the £900m already planned) and it is expected that Clinical Commissioning Groups (CCGs) and local authorities will use this year to transform the system. Consequently, a two year plan for the period 2014/16 had to be put in place by March 2014.

The BCF will support the aim of providing people with the right care, in the right place, at the right time, including expansion of care in community settings. This will build on CCG Out of Hospital strategies and local authority plans expressed locally through the Community Budget and Integration Pioneer programmes.

4.3. The Better Care Fund Plan was developed within the existing Whole Systems partnership between the local authority and the NHS, with service providers and with service user and carer representatives including HealthWatch, and reflects the shared aspirations for integrated care.

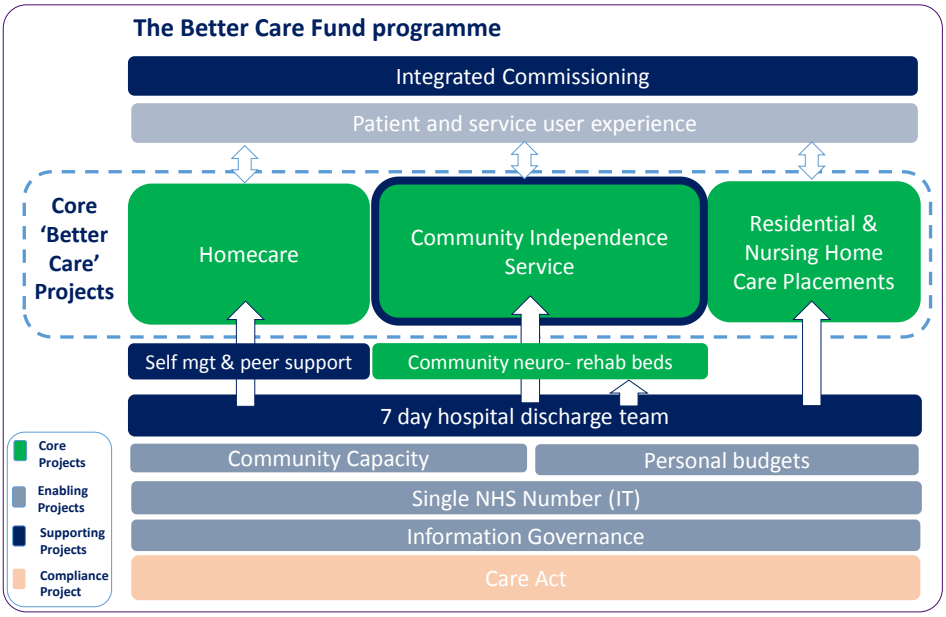
4.4. The outcomes to be achieved through the BCF are:

- A reduction in permanent admissions to residential care home
- Increased effectiveness of re-ablement
- A reduction in delayed transfers of care from hospital
- A reduction in emergency admissions to hospital
- An improvement in patient/service user experience
- Improvements in health-related quality of life for people with long term conditions.

5. REQUIREMENT FOR RESUBMISSION

5.1. The Health and Wellbeing Board approved the Better Care Fund Plan 2014-16 in March 2014 and the Plan was subsequently submitted to NHS England on 4th April. A summary of the BCF schemes is captured in the diagram below.

Enabling Better Care in Triborough



5.2. The Tri-borough BCF Plan was considered of good quality by NHS England (NHSE), the Local Government Association (LGA), DH and DCLG, and the three authorities were among a small number approached in July to be "fast-track" BCF authorities, providing a further example to other authorities of how an acceptable BCF Plan could be developed (although this offer was declined). The plan was rated 2nd nationally following more detailed work on finance and metrics and external assurance.

5.3. Other parts of the country, however, were not able to submit satisfactory plans. In addition concerns were expressed, particularly by the hospital sector, about the arrangements for local risk sharing and pay for performance. A key ambition of the BCF is reducing pressures arising from unplanned admissions to hospital. There was a lack of confidence in the ability of CCGs and local authorities to deliver the necessary changes to achieve this ambition within the timescale and, consequently, a fear that funding would be transferred from the NHS to local authorities but that acute activity would continue unabated.

5.4. Consequently, in July 2014, Health and Wellbeing Board Chairs received letters from the DH and the DCLG announcing some changes to the BCF Programme. The changes related to the Pay for Performance and Risk Sharing arrangements which commence in 2015-16.

5.5. Each area was asked to demonstrate how the BCF Plan will reduce emergency admissions, as a clear indicator of the effectiveness of local

health and care services in working better together to support people's health and independence in the community.

5.6. A proportion of the performance allocation (the local share of the national £1bn performance element of the £3.8bn fund) will be payable for delivery of a locally set target for reducing emergency admissions (they suggested at least 3.5% reduction). The balance of the allocation will be available upfront to spend on out of hospital NHS commissioned services, as agreed by the Health and Wellbeing Board. This provides greater assurance to the NHS and mitigates the financial risk to acute hospitals of unplanned acute activity. If the target for reducing admissions is not met, a proportion of the £1bn funding will remain with the NHS and not transfer to the BCF for joint use.

5.7. The original BCF guidance proposed that performance payments would be based on progress against four of the six national conditions and progress against the five national metrics and one local metric would be used to determine the level of payment for performance. Following July's national change to the Better Care Fund, only the indicator of unplanned admissions to hospital will determine payment for performance . Hospital providers have been asked to confirm agreement with the proposed reduction in non-elective activity.

5.8. Imperial NHS Trust and Chelsea and Westminster Hospital Foundation Trust have provided confirmation of agreement, subject to a detailed review of the CIS model to validate planning assumptions in relation to reduced emergency admissions and to understand fully the impact of the proposed changes on the care pathway, quality and safety, and workforce implications. The activity changes are reflected in the CCGs' QIPP and SAHF plans and will be reflected in their contracts with the trusts for 2015-16.

6. THE REVISED BETTER CARE FUND PLAN

6.1. The key changes from the BCF Plan previously approved by the Cabinet Member and by the Health and Wellbeing Board are as follows:

6.2. Target reduction of around 3.5% in total emergency admissions replaces the previous metric of approximately 5% reduction in *avoidable* emergency admissions. Funding linked to achievement of this target will be released by the CCG into the pooled budget on a quarterly basis, depending on performance, starting in May 2015, based on Q4 performance in 2014-15.

6.3. The remainder of the £1bn national fund (the performance element of the £3.8bn) will be released to the CCG upfront in Quarter 1 in 2015-16.

6.4. If the locally set target for reduction in emergency admissions is achieved, all of the funding linked to performance will be released to the Health and Wellbeing Board to spend on BCF activities. Achievement will be measured against the total figure for the whole area, not just against those activities within the BCF Plan.

6.5. If the target is not achieved, the remaining performance money will not leave the local area, it will remain with the CCG to compensate for unplanned acute activity or spend on NHS commissioned services, in consultation with partners on the Health and Wellbeing Board.

6.6. The system is designed to mitigate the financial risk to the CCG, whilst at the same time providing flexibility to deliver schemes that reduce acute activity. The revised arrangements need to be taken into account in both CCG and Local Authority planning for 2015-16.

6.7. Local authorities nationally have expressed concerns at the changes which step back from the core purpose of promoting locally led integrated care and reduce the resources available locally to protect social care and prevention initiatives.

6.8. However, within the Tri-borough area there is confidence that the target level of reduction in emergency admissions can be achieved so that the maximum level of allocation will be transferred to the BCF pooled budget for integrated services.

6.9. The NHS commissioned services can include NHS spend on those services currently commissioned by the local authority on behalf of the NHS or commissioned jointly through s75 agreements, which form a significant element in the Tri-borough BCF.

6.10. There is, however, a risk to Adult Social Care from these changes and the position will need to be monitored closely through the year to assess progress against target and the impact of any shortfall in the pooled budget on integrated services. A reduction in emergency admissions is likely to lead to an increased use of social care which needs to be funded.

6.11. The revised plan provides additional material in relation to the following areas:

- **The case for change** – analysis and risk stratified understanding of where care can be improved by integration, which has informed the key BCF

workstreams of community independence services including reablement and 7 day working.

- **A plan of action** – a clear evidence based description of the delivery chain which will support a reduction of emergency admissions, developed with all local stakeholders and aligned with CCG, local authority, provider and whole system strategies.

- **Strong governance –** confirmation of local management and accountability arrangements and description of tracking arrangements to monitor the impact of interventions, take action to address slippage, and robust contingency plans and risk sharing arrangements across providers and commissioners locally.

- **Protection of social care** – this reflects existing funding transferred via s256 from NHS England for current levels of work, plus new funding for Care Act responsibilities.

- **Alignment with acute sector and wider planning** – evidence of alignment with the NHS two-year operational plans, five year strategic plans, and plans for primary care as well as the local authority. Evidence is provided that providers are engaged in the BCF programme and have understood the impact of the plan on their services.

6.12. In addition the revised BCF Plan sets out in more detail the amount of funding going into carer support and the nature of that support.

7. CORE COMPONENTS OF THE BETTER CARE PLAN: the Community Independence Service and Integrated Operational Services

7.1. A core component of the BCF Plan is a new Community Independence Service (CIS). It accounts for more than half of the financial benefits of BCF to the three councils. It is a single service for all three boroughs. It integrates community health and social care services. This kind of service is often called “intermediate care.” It helps people in four ways:

(i) It is a single point of referral for intermediate care services. It is also the natural point of referral to the Adult Social Care assessment teams for people who need long-term services. It is an important starting-point for the new pathways that we are developing in the Customer Journey programme. Earlier this year, the research phase of Customer Journey told us that customers and health and social care professionals alike are confused about where to go for help. (We will explain this and other developments in Customer Journey in a paper later this year.)

(ii) The service quickly helps people who are very unwell with care at home. This is known as “rapid response,” which often involves nurses visiting within two hours of a referral to the CIS. Sometimes the crisis needs help from another profession, like a social worker or home care worker, because it is social not medical. For example, a family carer might be sick and the person they care for at risk because there is no-one to look after them. The rapid response service continues to help people while their situation stabilises, typically for between three and five days. It expects to help 70% of people who are referred avoid a stay in hospital.

(iii) The CIS is designed to help between 700 and 800 people in each borough avoid admission to hospital in 2015/16. This is significant and accounts for most of the financial benefits of CIS. But it is a small proportion of all unplanned admissions to hospital. Many people will continue to go to hospital. CIS helps when they no longer need care in hospital and are well enough to leave. This part of the service is called in-reach, and involves CIS staff working with staff in hospitals to plan for safe and timely discharge to the community, and to their own home as often as possible.

(iv) CIS helps people regain their independence following a crisis, whether the CIS managed the crisis at home or helped the person to come home following a stay in hospital. It offers integrated medical and social therapies. For most people it involves some combination of rehabilitation from a therapist, who might help them regain their mobility; and some “re-ablement,” in which people learn or relearn the skills and confidence to manage at home. It helps people avoid repeated crises and dependence on long-term care services—the services that consume most of Tri-borough’s Adult Social Care budgets.

7.2. Since May 2014 the Tri-borough BCF programme has developed a business case for this CIS.The business case explains why a single Tri-borough CIS that integrates community health and social care services is better value than three borough specific services and any service in which the health and social care elements are not integrated. The design supposed in the business case is based on Hammersmith & Fulham’s Virtual Ward CIS but includes successful features of existing services in other parts of Tri-borough.

7.3. The business case is based on a detailed statistical study of Tri-borough’s intermediate care services, including the CIS and re-ablement services of all three councils. From this baseline, it estimates the investment that is required to reduce unplanned admissions to hospital by 3.5% per year between 2015 and 2018, which is the principal performance target of the Better Care Fund. The estimate of investment allows for:

i) underlying growth in demand and costs from demographic change and inflation
ii) the additional cost to adult care of keeping people who would otherwise be in hospital in community services
iii) the additional demand that is created when new and better services create capacity for people with needs that existing services cannot meet.

7.4. The investment is calculated to help with BCF's main objective—reducing unplanned admissions to hospital. But in the same way that the investment allows for secondary effects of that investment, our estimates of savings include benefits in areas other than reduced hospital admissions—savings that mostly benefit the CCGs who pay for those admissions. CIS improves the quantity and quality of intermediate care and has direct financial benefits to hospital trusts and to the local authorities. Hospitals benefit because their beds are occupied only by people who need hospital care. This gives them more capacity to help during periods of high demand and to offer planned care, like elective surgery. It also reduces their losses when people stay in hospital for longer than they are funded by the NHS payment by results system. Good rehabilitation and re-ablement help people recover and stay will, so avoiding recurrent crises. They help reduce repeated trips to hospital and also the need for long-term social care services like residential care and home care, on which most of the Council's Adult Social Care budgets are spent.

7.5. The model of costs and benefits shows that an integrated, Tri-borough CIS saves money for all six Tri-borough commissioners: three CCGs and three councils. The savings do not fall proportionately across the commissioners. This section explains how the CCGs and councils have made the distribution costs and benefits fairer.

7.6. The CIS services that are in scope of the new CIS, and on which it will build, cost about £18.9m in 2014/15 of which about £6.5m is Adult Social Care CIS and re-ablement services. Investment of £4.6m in staff (including £2m social care), IT, and equipment will create total savings of £8M: a net saving of £3.4m. The savings come from:

i) providing medical care at home and hence avoiding a trip in an ambulance; a visit to Accident and Emergency; a stay in hospital; and often all three.
ii) shorter stays in hospital because CIS provides "post-acute" medical care at home

iii) more help to get well after a crisis, and so less need for long-term health and care services, especially residential care services.

7.7. The CCGs' return on investment is greater than the councils'. If the CCGs and councils invested the amounts we have estimated in our model in just their own elements of the service and also took savings only from their own budgets then

i) the CCGs would invest £1.7M in medical staff next year and save £4.5M mostly in reduced hospital activity.

ii) the councils would invest £2.9M mostly in social care staff and services and save £3.5M by reducing need for care homes and home care. (The model sums up estimates for each CCG and councils)[1].

7.8. In the absence of BCF, there would be a strong case to improve intermediate care for financial reasons and to offer a better service. (For example, a new CIS is a clear requirement of the "Customer Journey" programme of quality improvement to operational adult social care service.) The financial case for the service we have designed in BCF is less appealing to the councils than to the CCGs. But all six organisations need to participate if we accept that single Tri-borough service integrating community health and care services is more efficient and more effective overall than one that does not. We therefore need a fairer way of sharing benefits. Instead, as part of the wider budget-pooling arrangements in BCF, the CCGs have agreed they will fund all local authority investment in the new CIS in 2015/16. This means that the total net benefit to all the councils increases from £0.6M to about £5.2M. (The savings to each council can be found in Table 1). It also provides an opportunity to redeploy highly trained professional staff from long-term teams to CIS as part of the Customer Journey reforms.

8. DESIGNING AND IMPLEMENTING THE SERVICE

8.1. The BCF team believes that the implementation should establish the new service; invest in staff and systems; and focus on achieving the 2015/16 performance targets and savings. It should not seek to procure or create new organisations to deliver the service. Instead, the team believes that, so far as possible, existing providers should work under new contracts with better performance management and incentives.

[1] Figures for LBHF can be provided on request.

8.2. The councils have agreed that we will develop new management arrangements which are required to enhance our CIS services. This may involve one council acting as the lead provider CIS social care. A subsequent paper will explain this proposal when the details are clearer.

8.3. The CCGs are designing a new contractual relationship with their providers in which one is likely to act as a prime contractor or at least a lead provider coordinating the work of the rest. The CCGs are developing a fair and transparent means of choosing a lead.

8.4. A lead social care provider working with a lead NHS provider reduces the number of provider organisations accountable directly to the BCF commissioners from six to two. But the question arises, why not one provider?

8.5. Forming the new CIS with a single provider, or at least a single lead provider, for the beginning of the new service does not appear to be feasible.

8.6. Each Tri-borough council is a commissioner and provider of their existing CIS. They cannot account to a NHS lead provider in their role as CIS provider while also being a commissioner to whom that single NHS provider accounts.

8.7. Nor can the councils act as single lead provider for the whole CIS service because, again, each is a commissioner of the service and therefore has a conflict of interest. (It is also uncertain that we could accept clinical accountability for the health care component of CIS.)

8.8. These concerns appear largely theoretical, and would be likely to affect the management of risk if the new service suffered problems in the first year. Two providers, one social care and one health, working closely would seem better to support the important work of creating a new service quickly and achieving the first year's benefits. Beyond these new contractual arrangements for the first year of the new service, the commissioners believe that we should change the employment conditions of front-line staff as little as possible during implementation.

9. RISKS

9.1. Payment for performance in the Better Care Fund is based on reductions in unplanned admissions to hospital. The national formula for those arrangements is explained elsewhere in this report. The CIS is the means by which we will prevent large numbers of unplanned admissions. We

also expect that it will save money in other ways. The risks to those savings are as follows:

i) BCF does not achieve its target admission-avoidance
ii) The NHS do not convert the reductions in activity to cashable savings
iii) CIS increases activity in community beyond the forecasts in our cost benefit model. For example, the councils use less home care and more care home beds to manage demand than we planned, increasing our costs and reducing savings.

9.2. The mitigation is as follows:

i) The target for admission-avoidance is set around the national recommended level. It was repeatedly checked during the development of the business case and appears to be achievable and prudent.
ii) The cost-benefit analysis is cautious about other benefits. It allows margins of error where it makes assumptions that affect benefit. For example, it allows 15% contingency in case we underestimated the number of referrals for re-ablement that are required to keep people at home and out of care homes
iii) The business case, which has been agreed by CCG governing bodies, established five principles for risk-sharing. They say that the councils are paid for reducing activity and do not depend on realisation of cash savings in the NHS.
iv) The risk-sharing principles require a benefit monitoring system that can quickly identify a gap between the forecasts in the business case and the performance of the service.
v) The risk-sharing principles requires the commissioners to establish conditions on which any commissioner may withdraw from the service if it does not behave as expected and causes them unacceptable financial risk.
vi) The CCGs and councils are developing a risk-sharing agreement as part of the design and implementation of the new service.

10. CONDITIONS OF PAYMENT AND SHARING RISKS

10.1. The BCF requires CCGs and councils to share the financial consequences if the service does not reduce unplanned admissions to hospital. The national Payment for Performance arrangements provide the total funding to the CCGs. It is then applied against two elements: reduction in emergency admissions; and NHS commissioning of out of hospital services. The emergency admissions funding is released into the BCF pool on the basis of achievement of the target, assessed at the end

of each quarter from Q4 2014-15. The remaining funds are put into the BCF pool for investment in out of hospital services.

10.2. The CCGs can choose to invest additional funding into the BCF pool, and the Tri-borough CCGs have chosen to do this. Consequently, the risks to Tri-borough Adult Social Care are less than elsewhere because the CCG has committed to covering social care costs of the CIS in 2015-16, whether or not the emergency admissions target is achieved.

10.3. There is, nevertheless, a risk to the whole system of the new BCF services failing to deliver a reduction in emergency admissions (thus releasing resources for investment) and, potentially, increasing service demand by identifying unmet need. Consequently, close and frequent monitoring of implementation and outcomes will be required during 2015-16 to understand both the direct and indirect consequences of BCF implementation.

11. CONSULTATION

11.1. The revised BCF template seeks evidence of provider engagement in the development of the BCF programme and understanding of the impact which BCF changes would make to activity. Discussions have been held with major providers, acute and community, during June-September to increase their awareness of the detailed BCF programme. The strategic plans already agreed with local hospitals include a significant shift of work into the community and a reduction in emergency admissions.

11.2. Shaping a Healthier Future (SaHF) and the Out of Hospital Strategies set out the plan to reconfigure hospital services to focus on the needs of patients. These plans have been developed and consulted upon, with local authority, acute, community and mental health services and other local stakeholders fully engaged. The plans contained in the BCF are consistent with SaHF plans to shift work to community / primary care settings.

11.3. Acute Trusts are aware of the Better Care Fund and its intention to strengthen and harmonise the approach to community care and confidence in out of hospital provision, particularly through links to the Urgent Care Boards. The CCGs currently have risk sharing arrangements in place with local acute providers relating to activity reductions, and these would be maintained. Arrangements for further engagement at Chief Executive level prior to plan re-submission are in progress. There will also be further engagement with all providers over the coming months to

involve them in co-design of in depth solutions facing the health and social care economy in Tri-borough.

11.4. The BCF draws on the Joint Health and Wellbeing Strategy and Joint Strategic Needs Assessments across all boroughs, informed by patient and service user feedback. The approach to developing the BCF is characterised by co-design and co-delivery, supported by extensive stakeholder engagement, including with clinicians, other CCGs and local authorities, provider organisations and national bodies.

12. EQUALITY IMPLICATIONS

12.1. There no detrimental impact on equalities of health or access to health – improves access for people with long term conditions.

12.2. Implications verified/completed by: David Evans, Business Manager, Adult Social Care 020 8753 2154.

13. LEGAL IMPLICATIONS

13.1. The DH and the DCLG have established a multi-year fund, confirmed in the Autumn Statement, as an incentive for councils and local NHS organisations to jointly plan and deliver services, so that integrated care becomes the norm by 2018. A fund will be allocated to local areas in 2015/16 to be put into pooled budgets under Section 75 joint governance arrangements between CCGs and Councils. A condition of accessing the money in the Fund is that CCGs and councils must jointly agree plans for how the money will be spent, and these plans must meet certain requirements.

13.2. Legislation is needed to ring-fence NHS contributions to the Fund at national and local levels, to give NHS England powers to assure local plans and performance, and to ensure that local authorities not party to the pooled budget can be paid from it, through additional conditions in Section 31 of the Local Government Act 2003, which will allow for the inclusion of the Disabled Facilities Grant.

13.3. Implications verified/completed by: Andre Jaskowiak, Senior Solicitor, Bi-Borough Contract Law Team. Tel: 020 7361 2756.

14. FINANCIAL AND RESOURCES IMPLICATIONS

14.1. It is estimated that the programme will contribute to the delivery of around £13m in savings across Tri-borough partners by the end of 2015/16, if targets are fully met, as shown in the table below.

14.2. We have constructed a detailed financial and activity model which demonstrates the linkages and flows of costs and benefits across health and social care as a result of the new proposed CIS. The model is based on current data and agreed assumptions of the technical working group. At the core of this is the new Community Independence Service and the linkages between that service, homecare and residential and nursing home placements.

14.3. The model enables the local authority and CCGs to take an informed view over the different pressures and costs of redesigning core components of our of hospital care and the subsequent shift in activity and flows of people in order to come to a mutually beneficial agreement over the impacts and associated reimbursements. This is required to provide reassurance to the local authorities that social care will not be negatively impacted by the BCF.

14.4. The revised BCF Plan includes figures based on current estimates of costs and savings. The BCF ensures the continued protection of social care funding through grant to be maintained, provides for Care Act funding, provides for the 2015/16 new investment costs for social care for the CIS to be paid by Health and should generate savings on an ongoing basis.

14.5. The BCF brings together a number of existing funding sources for savings, summarised in the Table 1. The BCF in 2015/16 ensures that Tri-borough receives funding for the Care Act (£558k for LBHF), all the investment costs of the new Community Independence Service (£870k for LBHF) and should generate recurrent savings (£1.63k in LBHF in 2015/16). It also protects social care by continuing to pass through the Social Care to Benefit Health funding, currently worth £4.2m in LBHF.

Tri-borough Better Care Fund Financial Summary (September 2014)

Organisation	Holds the pooled budget? (Y/N)	Minimum contribution (15/16) '000	Actual contribution (15/16) '000	Anticipated Savings (15/16) '000
Westminster City Council	Y	*1,379*	*23,686*	2,281
Royal Borough of Kensington and Chelsea	Y	*874*	*22,254*	1,359
London Borough of Hammersmith and Fulham	Y	*1,052*	*48,622*	1,630
Central London CCG	N	*13,553*	*32,932*	2,511
West London CCG	N	*17,830*	*34,235*	2,633
Hammersmith and Fulham CCG	N	*13,148*	*31,533*	2,311
BCF Total		**47,836**	**193,262**	**12,725**

Actual savings will be tracked by borough or, where at tri-borough level, will be pro-rated by population. Our intention is for the local authorities to hold the pooled budget, but the pooling agreement will recognise that each scheme will be led by the most appropriate commissioner, either LA or CCG.

14.6. Implications verified/completed by: Rachel Wigley, Director of Finance, Adult Social Care 020 8753 3121

15. RISK MANAGEMENT

15.1. See Section 9 above and the risk matrix contained with the BCF Plan attached.

15.2. Implications verified/completed by: Mike Rogers, Head of Business Analysis, Adult Social Care 020 7641 2425

16. PROCUREMENT AND IT STRATEGY IMPLICATIONS

16.1. There are no procurement and IT strategy implications immediately arising from this report. The BCF Plan does include the implementation of IT and Information Governance developments which will be the subject of separate reports, as will any service procurements required as part of the development of services.

16.2. Implications verified/completed by: Sherifah Scott, Head of Procurement, Adult Social Care 020 7641 8954

LOCAL GOVERNMENT ACT 2000
LIST OF BACKGROUND PAPERS USED IN PREPARING THIS REPORT

No.	Description of Background Papers	Name/Ext of holder of file/copy	Department/ Location
1.	None		

LIST OF APPENDICES:

Appendix 1: Better Care Fund Plan 2014-16 Resubmission September 2014

Appendix 2: BCF Plan 2014-16 Finance and Outcomes Spreadsheets 2014